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14 CV 1368

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH BARBAGALLO,

Plaintiff,

vs.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

Civil Action No. _____

COMPLAINT

JUDGE KARAS

Plaintiff, JOSEPH BARBAGALLO, residing in Mahopac, New York 10541, by way of Complaint against the Defendant, alleges as follows:

1. Plaintiff is a resident of the State of New York, County of Putnam, with a principal residence in Mahopac, New York 10541.

2. Defendant, METROPOLITAN LIFE INSURANCE COMPANY, (hereinafter "MetLife" or "Defendant") is a disability insurance carrier, licensed to do business in the State of New York, with a principal place of business in New York City, New York.

3. Jurisdiction and venue are proper in this Court pursuant to 20 U.S.C. § 1001 *et seq.*, 28 U.S.C. § 1331 *et seq.* and 28 U.S.C. § 1391, *et seq.*

ESSENTIAL FACTS

A. Background

4. Plaintiff, Joseph Barbagallo (hereinafter "Mr. Barbagallo" or "Plaintiff"), is a 45-year-old married man with 2 children, all of whom reside in Mahopac, New York. Mr. Barbagallo was employed by Credit Suisse on March 4, 2003 as an Assistant Vice President of Market Data Research.

5. While employed by Credit Suisse, Mr. Barbagallo was a beneficiary under Credit Suisse's Group Disability Benefit Plan for Employees of Credit Suisse Securities (USA), LLC, underwritten by MetLife as Policy No. 517 in conjunction with Credit Suisse's Group Healthcare Plan. The Policy is attached hereto as **Exhibit A**.

6. Pursuant to the terms of the Policy, the pertinent provisions for purposes of this Complaint are as follows:

> "Disability occurs, if due to sickness pregnancy or accidental injury:
>
> - You are receiving appropriate care and treatment from a doctor on a continuing basis;
> - You are unable to earn more than 80% of your 'pre-disability earnings' (or indexed pre-disability earnings) at **your own occupation** from any employer in your local economy; and
> - Your loss of earnings is a direct result of your sickness, pregnancy, or accidental injury."

7. In or about August 2004, Mr. Barbagallo was injured as a passenger in a Metro North train accident when his commuter train struck a barrier. He was thrown to the floor and severely injured his back. More specifically, he sustained an L4-L5 disk herniation which caused him severe lower back and leg pain.

8. As a result, Mr. Barbagallo first applied for short term disability benefits in September 2004 which benefits were approved by MetLife for the period of August 24, 2004 through February 21, 2005.

9. In or about February 2005, Mr. Barbagallo filed a claim for long term disability benefits which were also approved by MetLife. At that time, MetLife had concluded that the medical records supported Mr. Barbagallo's restrictions and limitations which precluded him from working either in his own occupation or any other occupation. Accordingly, MetLife paid Mr. Barbagallo disability benefits in the amount of $4,415.00 per month as per the terms of the Policy.

10. Also, in February 2005, MetLife urged Mr. Barbagallo to apply for Social Security Administration (SSA) disability benefits which he did, in fact, do at or around that time. After several denials and appeals, Mr. Barbagallo was ultimately awarded SSA disability benefits on May 2, 2011 retroactive to February 2005.

11. As a result thereof, SSA paid Mr. Barbagallo retroactive benefits for the period of February 2005 through May 2011. At that time, MetLife determined, pursuant to terms of the Policy, that it had overpaid Mr. Barbagallo $185,170.08, since the Policy provided that Mr. Barbagallo's benefits be offset by any SSA disability benefits. Accordingly, MetLife demanded from Mr. Barbagallo the overpayment of $185,170.08.

12. In the later part of 2011 and early part of 2012, Mr. Barbagallo did, in fact, reimburse MetLife the full sum of $185,170.08

13. Upon MetLife being reimbursed from Mr. Barbagallo the overpayment of $185,170.08, MetLife decided it was now time to terminate his disability benefits.

14. Thus, on October 15, 2012, MetLife terminated Mr. Barbagallo's benefits, not on the basis of any objective medical evidence, but solely on the basis of surveillance videos conducted of Mr. Barbagallo from July 17 to July 19, 2012 and August 9 to August 11, 2012. The surveillance occurred ironically, but not surprisingly, within months of MetLife being reimbursed the sum of $185,170.08.

15. MetLife's termination of Mr. Barbagallo's benefits based on the surveillance only is clearly evident in MetLife's termination letter of October 15, 2012 where MetLife stated:

> "Reviews of your activities were performed in July and August 2012 during which time your home appeared to be undergoing interior renovation and/or repair. During those review periods, you were observed to be performing at a functional level above the abilities which have been indicated by your treating health care providers on 4 of the 6 days. The activity reports noted you were ambulating around your yard in a normal gait without apparent difficulty or need of any assistive devices such as a cane. You were observed bending at the waist; lifting and carrying 15' long 2x4 boards into your residence, carrying a ladder from your shed to the back of the house; driving; entering and exiting your vehicle; and standing and walking. At all times during which you were observed, you were noted to ambulate and move without difficulty, the use of assistive devices, or any apparent distress.
>
> ***
>
> The activity level observed over the course of the review periods demonstrates you have functional ability which is significantly greater than, and contrary to, the restrictions and limitations provided by Dr. Rho as of May 30, 2012; and does not support continued severity of impairment from either your ankle or back conditions which would prevent your ability to perform work activity within your sedentary occupation. The functional ability which was evidenced in your physical activities during the period in which you were observed exceeds the functional level required to work within your occupation as a data analyst. Therefore, your claim has been terminated effective October 15, 2012 which is the date of this letter."

16. The sole reason that MetLife relied only on the surveillance was because MetLife, from 2004 to 2012, conducted not one medical evaluation of Mr. Barbagallo and obtained not one medical report or opinion which would contradict the plethora of medical information in the administrative record supporting Mr. Barbagallo's disability. With not even a scintilla of objective medical evidence, MetLife had no other choice but to terminate Mr. Barbagallo's benefits on the sole basis of the surveillance videos.

17. As set forth below, MetLife's decision to terminate Mr. Barbagallo's benefits based solely on the surveillance videos was not only arbitrary and capricious, but a travesty of injustice because the man observed doing the lifting, carrying, reaching, twisting, etc. was not Mr. Barbagallo. In essence, **MetLife got the wrong guy!**

B. Plaintiff's Administrative Appeal of MetLife's Decision of October 15, 2012

18. In response to MetLife's decision to terminate Mr. Barbagallo's benefits as set forth in its letter of October 15, 2012, Mr. Barbagallo filed an administrative appeal. During the appeal process, Mr. Barbagallo received and reviewed the administrative record including the surveillance videos.

19. Upon Mr. Barbagallo's review of the surveillance videos, it became obvious that none of the men surveilled doing those activities such as bending, lifting, carrying 15-foot long 2x4's, carrying a ladder, etc. were of Mr. Barbagallo. Therefore, in connection with Mr. Barbagallo's appeal, he submitted to MetLife various affidavits from the individuals who were surveilled thus making it crystal clear to MetLife that it made a mistake and **got the wrong guy**.

20. Thus, MetLife found itself between a rock and a hard place. Instead of "doing the right thing" by reinstating Mr. Barbagallo's benefits, MetLife, in the most egregious breach of one's fiduciary duty, chose to ignore its mistake, **and instead decided for the first time in 8 years,** to obtain a medical report from one of its "hired guns" to support a termination of benefits.

21. More specifically MetLife obtained a medical report from Dr. Lucia McPhee whose report was a "paper review" only. At no time did Dr. McPhee ever clinically examine or evaluate Mr. Barbagallo and despite all of the objective medical evidence in the administrative record supporting Mr. Barbagallo's continued disability, Dr. McPhee, as she was hired to do, disregarded it all and concluded that Mr. Barbagallo is not disabled.

22. Although Dr. McPhee found that Mr. Barbagallo's MRI of his lumbar spine on August 30, 2011 was consistent with advanced disk generation and that the MRI of the S1 nerve route can be associated with radicular symptoms, she turned the other cheek and astonishingly concluded that:

> "Even if there was a component of discogenic low back pain contributing to paraspinal muscle spasm, this should be manageable with conservative measures and not preclude a sedentary level of activity, if adequate position changes allowed and ergonomic principles are incorporated for optimal back posture."

23. Dr. McPhee rendered her opinion without any factual or medical basis. It was conclusory only and highly suspect given the fact that Dr. McPhee never clinically examined or evaluated Mr. Barbagallo.

C. **Mr. Barbagallo's Response to Dr. McPhee's Report**

24. In response to Dr. McPhee's unsubstantiated report, Mr. Barbagallo submitted additional medical reports from his treating physicians, Dr. Michael Bank and Dr. Arefin Siddique. Both doctors were of the opinion that Mr. Barbagallo continues to suffer from radiculopathy, lumbar disc herniation and lumbar degenerative disc disease. Also, both doctors concluded that the restrictions and limitations associated with Mr. Barbagallo's disability prevent him from performing his prior occupation, even if the duties associated with that occupation are sedentary in nature.

D. **Last Ditch Effort By MetLife**

25. In a last ditch effort to support its termination of Mr. Barbagallo's benefits, MetLife directed him to attend an Independent Medical Exam with Dr. Sunitha Polepalle. The IME occurred on November 11, 2013. Ironically, Dr. Polepalle's diagnosis of Mr. Barbagallo was **substantially similar** to the diagnoses of Dr. Bank and Dr. Siddique. More specifically, Dr. Polepalle diagnosed Mr. Barbagallo with the following:

Lumbar Disk Herniation
Lumbar Radiculopathy
Lumbar Degenerative Disk Disease
Low Back Pain
Left Leg Pain
Right Ankle Pain

26. Dr. Polepalle also found that Mr. Barbagallo does have restrictions and limitations in terms of pulling, pushing, lifting as well as limited range of motion and weakness in the left lower extremity. **Nowhere in Dr. Polepalle's report does she state that Mr. Barbagallo can return to work at any level.**

27. Dr. Polepalle's opinion, together with the medical findings and opinions of Dr. Bank and Dr. Siddique, support a finding that Mr. Barbagallo has sufficient restrictions and limitations to prevent him from preforming any occupation, even one that is sedentary in nature.

E. Denial of Administrative Appeal

28. Notwithstanding all of the above, Mr. Barbagallo's appeal was denied by MetLife on December 12, 2013 and his benefits have not been reinstated. In making that determination, MetLife ignored the plethora of objective medical evidence supporting a finding of disability while also ignoring the findings of the SSA.

29. For MetLife to urge Mr. Barbagallo to apply for SSA disability benefits..... for MetLife to then seek reimbursement from Mr. Barbagallo of $185,180.08 in overpayments after Mr. Barbagallo was awarded retroactive SSA benefits from 2005 to 2011.... and for MetLife to then terminate Mr. Barbagallo's benefits shortly after its receipt of $185,180.08, is a very clear, but nevertheless, alarming signal of MetLife's ultimate plan to terminate Mr. Barbagallo's benefits regardless of the objective medical evidence in the administrative record.

30. Mr. Barbagallo has exhausted all his administrative remedies.

AS AND FOR A FIRST CAUSE OF ACTION

31. Plaintiff repeats and realleges each and every allegation set forth in Paragraphs 1 through 30, as if fully set forth at length herein.

32. Plaintiff is totally disabled within the meaning of the terms of the subject Policy attached hereto as Exhibit A and, as such, is entitled to total disability benefits thereunder.

33. Defendant's decision on December 12, 2013 denying Plaintiff's appeal and upholding the termination of Plaintiff's benefits, was arbitrary and capricious, and not based on

substantial evidence. Plaintiff was also deprived of a full and fair review when he appealed the termination of benefits administratively.

34. Moreover, Defendant is acting under a clear conflict of interest within the meaning of *Metropolitan Life Insurance Company v. Glen*, 128 S. 2343 (2008), which conflict has poisoned its decision-making in this case, to Plaintiff's great prejudice.

35. By virtue of the foregoing, the Defendant has breached the terms of the said Policy and has violated the requirements of the Employee Retirement Income Security Act, 29 USC § 1132(a)(1)(B) (§ 502(a)(1)(B) and the applicable regulations thereunder.

AS AND FOR A SECOND CAUSE OF ACTION

36. Plaintiff repeats and realleges each and every allegation set forth above in Paragraphs 1 through 35, as if fully set forth again herein.

37. By virtue of the foregoing, the Defendant's decision on December 12, 2013 constitutes a breach of the Defendant's fiduciary duty owed to Plaintiff under § 502(a)(2), 29 USC § 1132(a)(2), placing Defendant's own interests over that of the Plaintiff.

WHEREFORE, Plaintiff demands judgment against the Defendant as follows:

1. Declaring Plaintiff totally disabled within the meaning of the Defendant's Policy attached hereto as Exhibit A.

2. Ordering the Defendant to immediately place the Plaintiff back on claim for total disability under the terms of the said Policy, retroactive to the date of wrongful termination on October 15, 2012.

3. Awarding to Plaintiff his costs of suit, including reasonable attorney's fees.

4. Awarding the Plaintiff interest on all unpaid benefits.

5. Granting such further relief as this Court may deem just and proper.

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Dated: 2/26/14

By: _____
MICHAEL E. QUIAT (MEQ-8238)

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Disability Benefits

Summary Plan Description

Effective January 1, 2013

Contents

Group Disability Benefits Plan

Introduction

Credit Suisse Securities (USA) LLC (Credit Suisse or the Bank) offers the Disability Benefits Plan to provide you with an income replacement benefit if you are unable to work because of an illness or injury.

The following plans comprise the Disability Benefits Plan:

- The Short-Term Disability Plan (STD Plan)—which provides an income replacement benefit for absences that last more than seven consecutive calendar days, up to a maximum of 180 calendar days; and
- The Long-Term Disability Plan (LTD Plan)—which provides an income replacement benefit for absences that last longer than 180 calendar days.

Your coverage under the STD Plan component of the Disability Benefits Plan is automatic as long as you are an eligible employee. You are automatically enrolled at the time of hire and pay the cost for coverage under the LTD Plan or, if you wish, you can "opt out" of this coverage.

These benefits are meant to be used when and as needed. However, they are intended to be used only for extended absences due to illness or injury which cause you to be unable to work. Credit Suisse and its appointed representatives will make every reasonable effort to verify your illness or injury.

This Summary Plan Description (SPD) provides important details about these plans, including:

- Rules on eligibility and participation;
- Details about each benefit amount;
- How each component of the Disability Benefits Plan works—separately and together;
- How to submit claims; and
- Legal and administrative information.

If you have any questions, please refer to "Resources."

This document serves as your Summary Plan Description (SPD) and your plan document as required under the Employee Retirement Income Security Act of 1974 (ERISA). Its purpose is to provide you with a brief, clear, and meaningful description of the plans that comprise the Group Disability Benefits Plan of Credit Suisse Securities (USA) LLC (the Disability Benefits Plan) and to provide the administrative details of these plans, including your rights as a plan participant. This SPD is effective January 1, 2013.

Additional terms and conditions about the Disability Benefits Plan are included in the contracts and certificates of insurance, which are the documents that legally govern these plans. In the event of any discrepancies between this Summary Plan Description and the official plan documents, or between oral or written statements made to you and the official plan documents, the provisions of the official plan documents will prevail. These include the following certificates of insurance:

- Your Employee Benefit Plan—Short Term Disability;
- New York Statutory Disability;
- New Jersey Statutory Disability; and
- Your Employee Benefit Plan—Long Term Disability.

These certificates of insurance are available upon request to the Credit Suisse Benefits Service Center.

If any of the terms and conditions in these other documents conflict with the terms and conditions of this SPD, the plan administrator or claims administrator, as appropriate (or third-party administrator designated by the plan administrator), shall resolve the conflict in its sole discretion. Any such interpretation will be conclusive and binding on all persons unless the administrator's action is held to be arbitrary or capricious.

How the STD Plan Works

The STD Plan

The Short-Term Disability (STD) Plan is designed to provide you with income replacement if you become "disabled" and are unable to work. The plan also includes:

- A return-to-work program that focuses on vocational rehabilitation, identifying the necessary training, therapy, job modifications, and accommodations that can help you return to work; and
- An easy claim application process that you can start with a call to the Credit Suisse Benefits Service Center at **1-888-325-2732**.

Please note: You should initiate the claim application process within seven calendar days following your original date of disability (or as soon thereafter as reasonably possible).

Most aspects of the plan work in the same way for all plan participants; however, there are some minor differences based on the state where you work. These differences are noted in each section when they apply.

Definition of Disabled Under the STD Plan

Under the STD Plan, you are disabled if, due to sickness, pregnancy, or accidental injury:

- You are receiving appropriate care and treatment from a doctor on a continuing basis;
- You are unable to earn more than 80% of your "pre-disability earnings" at your own occupation from any employer in your local economy; and
- Your loss of earnings is a direct result of your sickness, pregnancy, or accidental injury.

Please note: Economic factors such as recession, job obsolescence, pay cuts, and job-sharing will not be considered in determining whether you meet the loss-of-earnings test. Also, if you are in a position that requires a license, loss of the license for any reason does not, in itself, constitute "disability."

Participating Affiliates

The following Participating Affiliates have adopted the plan:

- Asset Management Finance LLC;
- Column Financial Inc.;
- Column Guaranteed LLC;
- Credit Suisse AG, New York Branch;
- Credit Suisse Alternative Capital LLC;
- Credit Suisse Asset Management LLC; and
- Credit Suisse Holdings (USA), Inc.

Who Is Eligible for STD Plan Benefits

To be eligible for STD Plan benefits, you must be:

- Classified by and work for Credit Suisse or a "Participating Affiliate" as its employee;
- On a Credit Suisse U.S. payroll; and
- Regularly scheduled to work at least 20 hours a week.

If You Are Scheduled to Work Less Than 20 Hours a Week

While you are not eligible for STD benefits under the plan, depending on the state where you work, you may be eligible for certain state-provided benefits.

Notes on STD Eligibility
Employees on International Assignment

You are eligible for STD coverage while you are on international assignment, as long as you meet the other eligibility requirements. While you are on an international assignment, you are not eligible for state benefits, even if you worked in California, New Jersey, or New York prior to your assignment.

Who Is Not Eligible for STD Plan Benefits

You are not eligible for coverage under the STD Plan if you:

- Do not meet the requirements outlined under "Who Is Eligible for STD Plan Benefits";
- Are classified by and work for the Bank as an independent contractor or consultant or through an agency, consulting firm, payroll service, subcontractor, or other third-party provider; or
- Are classified by and work for the Bank as an intern.

When STD Coverage Begins

Your STD Plan coverage begins on the first day of active employment.

Cost of STD Coverage

Credit Suisse pays the full cost of your STD Plan benefits. However, if you work in New York, New Jersey, or California, see the sections of this SPD that apply to you for specific information on the cost of your coverage.

STD Benefit Amounts

If you become disabled and are unable to work because of an illness or injury, the STD benefit you will be eligible to receive is described in this section. Your benefit is dependent on the state where you work.

In no case will your STD Plan benefit be less than $20 a week—the minimum STD Plan benefit—unless you are in an overpayment situation or receiving a return-to-work incentive (see "Return-to-Work Incentives").

You are eligible to receive an STD Plan benefit equal to 100% of your pre-disability earnings (see "STD Plan Pre-Disability Earnings") starting on the first day of absence due to a non-work-related illness or injury. This benefit will continue for the duration of your disability, up to a maximum of 180 calendar days.

STD Plan Pre-Disability Earnings

For purposes of the STD Plan, your pre-disability earnings are your regular gross weekly salary or hourly wages from Credit Suisse as of the day before your disability begins.

Pre-disability earnings do not include:

- Awards;
- Overtime pay;
- Credit Suisse contributions made on your behalf to any deferred compensation arrangement or pension plan; or
- Any additional compensation provided by Credit Suisse in excess of your base salary or hourly wages.

If you do not have regular work hours, pre-disability earnings are based on the average number of hours you worked per week during the preceding 52 calendar weeks (or, if less, your period of employment), but in no event will the number of hours be more than 40.

If You Work in New York or New Jersey

Your benefit will differ in the following ways:

Cost of Coverage

If you work in New York, you will be charged a premium each pay period for your state-provided STD coverage. If you work in New Jersey you will be charged the mandatory state tax for STD Plan coverage.

Benefit Amounts in New York and New Jersey

Your plan benefits will be reduced by any New York or New Jersey State benefit you are eligible to receive. The timing of when this occurs depends on any other disability benefits you may be receiving.

Please note: Your 180 days of STD benefit is counted differently under the state benefit plans for New York and New Jersey than under your STD benefit from the Bank. Bank-provided STD benefits begin counting your 180-calendar-day period of disability from your first day of absence.

For additional New Jersey State disability information, go to **www.state.nj.us/humanservices/clients/disability**.

For additional New York State disability information, go to **www.health.state.ny.us/nysdoh/prevent/main.htm**.

If your leave of absence lasts beyond 180 days from your first day of absence, there may be an overlap between your state disability benefit and any LTD benefit you may be eligible for under the LTD Plan. If your state disability benefit overlaps your LTD benefit period, your LTD benefit will be offset by any state benefit you receive while on LTD.

If You Work in California

Your benefit will differ in the following ways:

Cost of Coverage

You will be charged the mandatory state tax for STD Plan coverage.

Benefit Amounts If You Work in California

Your state benefit is paid directly by the state of California and offsets all benefits you are eligible to receive under the STD Plan. You will receive a separate check for your state benefit and reduced check from the STD Plan for the period of your state benefit, which can be up to 52 weeks.

Your Credit Suisse STD benefit will be reduced by the weekly amount received under the California State disability program for the period you are disabled, as defined by the California State disability program. For maternity cases, this is either the first six weeks (for normal delivery) or eight weeks (for cesarean delivery). If California State disability informs you differently, please notify the Credit Suisse Benefits Service Center immediately.

Please notify the Credit Suisse Benefits Service Center of the amount of state disability benefits you receive so that an adjustment can be made to your Credit Suisse disability benefits. The state program must pay you directly. For more information about this program—or to request a claim form—call **1-800-480-3287** or log on to **www.edd.ca.gov**.

Filing a Claim for State-Provided STD Benefits

If you work in California and are eligible to receive a state STD benefit, you must file a separate claim for this benefit. In New York and New Jersey, you do not need to file a separate claim form. To request a claim form for state benefits, or for more information about any state STD benefit you may be eligible to receive, call the appropriate number listed below:

- California—**1-800-480-3287**
- New Jersey—**1-609-292-7060**
- New York—**1-800-353-3092**

Other Sources of Income Under the STD Plan

Your STD Plan benefit payments will be reduced by other sources of income that you receive because of your disability or retirement, as well as by any benefits available to your spouse and dependents because of your disability or retirement (regardless of marital status or their place of work). However, if you are divorced or legally separated, benefits paid directly to your dependents (and not constructively received by you) will not be counted.

These other sources of income include:

- Any salary continuation plan or other income provided by Credit Suisse or any other employer.
- Any disability benefits under Workers' Compensation law, Unemployment Compensation law, the Railroad Retirement Act, or similar legislation.
- Any accident and health plan sponsored by Credit Suisse that may provide disability benefits.
- Social Security in the form of primary Social Security disability benefits or dependent Social Security disability benefits. (**Please note:** You must apply for Social Security disability benefits as soon as you qualify for these benefits.)
- Any disability income provided by a group, wholesale, or franchise program in which you are enrolled by virtue of your occupation.
- Any other source through which you receive, or are entitled to receive, benefits because of your disability or retirement, except the qualified savings plan, lump-sum pension payouts, and non-qualified deferred compensation plans sponsored by Credit Suisse.
- A no-fault automobile plan.

Tax Treatment of STD Plan Benefits

All regular withholdings for federal income taxes—and state and local income taxes, where applicable—will continue while you are disabled and will be deducted from your STD Plan benefits.

Maximum Benefit Payment Period

You will receive STD Plan benefits for a maximum 180 calendar days, at which time your STD Plan benefits end. If your disability lasts longer than 180 calendar days, you may be eligible to receive continuing income benefits under the LTD Plan (see "How the LTD Plan Works") if you have elected coverage under that plan.

Recurring Disability Under the STD Plan

If you return to work after receiving STD Plan benefits and within 30 calendar days you become disabled again due to the same or a related condition, your original claim will resume. You will not have to complete another elimination period (seven consecutive calendar days of disability) before starting to receive STD benefit payments again. However, if after 30 or more calendar days of work you become disabled again—even if due to the same or a related condition as your prior period of disability—you will begin a new period of disability under a new claim.

Please note: If your disability recurs within 30 calendar days, you will not qualify for any change in STD benefits that may otherwise apply due to a change in your pre-disability earnings or plan terms, provisions, or conditions.

Concurrent Disability Under the STD Plan

If a new disability occurs while STD Plan benefits are payable, it will be treated as part of the same period of disability and benefit payments will continue subject to:

- The 180-calendar-day maximum on the duration of benefit payments for each period of disability; and
- Any limitations or exclusions that may apply to the new cause of disability (see "When STD Plan Benefits Will Not Be Paid").

When STD Plan Benefits Will Not Be Paid

In general, STD Plan benefits will not be paid for any disability resulting from:

- War, insurrection, or rebellion;
- Active participation in a riot;
- An intentionally self-inflicted injury or attempted suicide; or
- Committing a felony.

Workers' Compensation and STD

If there is a reasonable basis for you to apply for Workers' Compensation benefits, you must do so. If your illness or injury qualifies for Workers' Compensation benefits and you do not apply to receive them, your STD Plan benefits will be suspended. Any payments received through Workers' Compensation will be applied as an offset to your STD benefit. When receiving both Workers' Compensation and STD, your combined benefit is not to exceed more than 100% of your pre-disability earnings. You should contact the Credit Suisse Benefits Service Center for assistance with coordinating the offset.

When Your STD Plan Benefits Will End

Your STD Plan benefits will end the date on which one of the following events occurs (whichever happens earliest):

- You receive STD Plan benefit payments for 180 calendar days;
- Your disability ends;
- You fail to provide the claims administrator any required information to substantiate your disability (see "Filing a Claim for STD Benefits");
- You fail to attend a medical examination requested by the claims administrator; or
- Your death.

Please note: If you are disabled and the STD Plan terminates or you cease to be an eligible employee—either during the first seven consecutive calendar days of your disability (before STD benefit payments begin) or while receiving STD benefit payments—you will continue to be eligible to receive benefit payments from the plan for as long as you remain disabled, up to a maximum of 180 calendar days.

When Your Participation in the STD Plan Ends

If you are not disabled and are not receiving disability benefit payments, your STD Plan coverage will end on the date that the earliest of the following events occurs:

- A policy or plan terminates; or
- You cease to be an eligible employee.

Impact on Other Benefits While on STD

Employees on a Leave of Absence
In General

If you go on a qualifying leave of absence under the Family and Medical Leave Act ("FMLA"), then to the extent required by the FMLA, the Bank will continue to maintain your participation in your health benefits on the same terms and conditions as if you were an active employee.

Employees on a Paid Leave of Absence

You continue to be eligible to participate in your health benefits while you are on a paid leave of absence (FMLA or non-FMLA). Payroll deductions continue and you can continue to submit claims for eligible expenses incurred by you and your eligible dependents.

Further, as long as you are approved for STD benefits by the claims administrator, your benefits will continue with the following exceptions:

- Tuition Assistance Program;
- Business Travel Accident Insurance;
- Back-Up Care Advantage Program; and
- Commuter Benefit Program.

Filing a Claim for STD Benefits

If your absence extends beyond seven consecutive calendar days, you must file a claim for STD Plan benefits by contacting the Credit Suisse Benefits Service Center at **1-888-325-2732**.

You also will have to submit—at your own expense and subject to the claims administrator's satisfaction—certain required information, including:

- Proof of disability;
- Evidence of continuing disability;

- Proof that you are under the appropriate care and treatment of a doctor throughout your disability;
- Information about other income benefits; and
- Any other material information related to your disability.

Proof of disability must be submitted within 45 days after the end of your elimination period. The elimination period for STD is seven consecutive calendar days of disability. No benefits will be payable for claims submitted more than three months after the date of disability. However, you can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give written proof of disability during the three-month period; and
- Proof of disability satisfactory to the claims administrator was given as soon as reasonably possible.

You will receive written notification from the claims administrator regarding your claim within a reasonable time period, but not later than 45 days after receipt of the claim by the claims administrator. This initial notification period may be extended up to two times for up to 30 days each (up to a total of 105 days) if an extension is necessary due to matters beyond the control of the plan. You will be notified before the end of the initial 45-day period and, if a second extension period is needed, by the end of the initial 30-day extension period, why the extension is necessary and when a decision is expected to be made.

If an extension is necessary because you failed to submit necessary information to decide the claim, the notice will specify what additional information is necessary. You will have at least 45 days to provide the requested information.

If Your Claim for STD Benefits Is Denied

If your claim for STD benefits is denied, in whole or in part, you will receive a written notice that contains:

- The specific reason(s) for the denial;
- The specific plan provisions on which the denial is based;
- If an internal rule, guideline, protocol, or similar criterion was relied on in making a claim determination, either a copy of the actual rule, guideline, protocol, or other criterion; or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy, free of charge, of the internal rule, guideline, protocol, or other similar criterion that was relied upon to determine the claim;
- Any additional material or information that is needed to perfect the claim and an explanation of why it is necessary; and
- The plan's claim-review procedures and applicable time limits.

Filing an Appeal

After receiving the denial notice, you or your authorized representative may ask for a full and fair review of the decision by writing to the claims administrator.

You are entitled to be represented by an attorney or other authorized person through all phases of the review process, including reconsideration of a denied claim.

You must make this request within 180 calendar days of the date you receive written notice of the denied claim. You or your authorized representative will be given reasonable access to all documents, records, and information relevant to the claim for benefits, and you may request copies free of charge. You also can submit written comments, documents, records, and other information relating to the claim. Review of your claim will take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

Appeal Decision

The claims administrator will review the appealed claim and make a decision based on all comments, documents, records, and other information that you have submitted.

Discretionary Authority of Claims Administrator

The claims administrator will serve as the reviewer of the STD Plan. It will have sole and complete discretionary authority to determine conclusively for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the administration and interpretation of the plan. This authority includes, without limitation, determination of questions arising from or relating to the participation of eligible employees and eligibility for benefits, the relevant facts, the amount and type of benefits payable to any participant, and the construction of all terms of the plan.

Timing of Notification of Appeal Decision

In most cases, you will receive the claims administrator's written notification of the appeal decision within a reasonable period of time, but not later than 45 days after receipt of the appeal request. If necessary, the period may be extended for an additional 45 days.

If special circumstances require additional time for processing your request, you will be notified as to why an extension is necessary and when a decision is expected to be made.

If your appeal is denied, in whole or in part, you (or your authorized representative) will receive a written notice that contains:

- The specific reason(s) for the denial;
- The specific plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the claim; and
- If an internal rule, guideline, protocol, or similar criterion was relied on in making a claim determination, either a copy of the actual rule, guideline, protocol, or other criterion; or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy free of charge of the internal rule, guideline, protocol, or other similar criterion that was relied upon to determine the claim.

Eligibility for benefits is intended to be determined solely on the basis of information supplied to the claims administrator. Benefits cannot be granted or denied on the basis of information that has not been submitted in connection with a claim.

How the LTD Plan Works

The LTD Plan

The Long-Term Disability (LTD) Plan is designed to provide you a monthly benefit if you become "disabled" and are unable to work and your disability continues for more than 180 calendar days. The plan also includes:

- An ***early assistance program*** offering rehabilitation assistance both before and after you file a claim for LTD Plan benefits;
- A ***return-to-work program*** that focuses on vocational rehabilitation, identifying the necessary training, therapy, job modifications, and accommodations that can help you return to work; and
- A ***Social Security assistance program*** to help facilitate the Social Security Disability Insurance application and approval process.

Benefits under the LTD Plan are paid by the claims administrator and insurer, not by the Bank. You do not need to file claim form or call the Benefits Service Center to initiate an LTD claim. The claim is transitioned from STD to LTD automatically.

Definition of Disabled Under the LTD Plan

Under the LTD Plan, you are disabled if, due to sickness, pregnancy, or accidental injury:

- You are receiving appropriate care and treatment from a doctor on a continuing basis;
- You are unable to earn more than 80% of your "pre-disability earnings" (or **indexed** pre-disability earnings) at your own occupation from any employer in your local economy; and
- Your loss of earnings is a direct result of your sickness, pregnancy, or accidental injury.

Please note: Economic factors such as recession, job obsolescence, paycuts, and job-sharing will not be considered in determining whether you meet the loss-of-earnings test. Also, if you are in a position that requires a license, loss of the license for any reason does not, in itself, constitute "disability."

Participating Affiliates

The following Participating Affiliates have adopted the plan:

- Asset Management Finance LLC;
- Column Financial Inc.;
- Column Guaranteed LLC;
- Credit Suisse AG, New York Branch;
- Credit Suisse Alternative Capital LLC;
- Credit Suisse Asset Management LLC; and

- Credit Suisse Holdings (USA), Inc.

Who Is Eligible for LTD Plan Benefits

To be eligible for LTD Plan benefits, you must be:

- Classified by and work for Credit Suisse or a "Participating Affiliate" as its employee;
- On a Credit Suisse U.S. payroll; and
- Regularly scheduled to work at least 20 hours a week.

Notes on LTD Eligibility
Employees on International Assignment

You are eligible for LTD coverage while you are on international assignment as long as you meet the other eligibility requirements outlined under "Who Is Eligible for LTD Plan Benefits."

Rules on Reinstatement of LTD Coverage

If your coverage under the LTD Plan ends, and within three months of your loss of eligibility you return to work and become an eligible employee again, you can elect LTD coverage without having to provide evidence of insurability (EOI) or undergoing a waiting period. If you do not regain eligibility under the plan within the three months, you will have to undergo a waiting period and provide EOI to enroll.

Who Is Not Eligible for LTD Plan Benefits

You are not eligible for coverage for any of the components of the LTD Plan if you:

- Do not meet the requirements outlined under "Who Is Eligible for LTD Plan Benefits";
- Are classified by and work for the Bank as an independent contractor or consultant or through an agency, consulting firm, payroll service, subcontractor, or other third-party provider; or
- Are classified by and work for the Bank as an intern, temporary employee, or seasonal worker.

If you do not enroll in the LTD Plan during your first 30 days of employment, or elect to increase your LTD coverage at a later date, you may be required to provide evidence of insurability (EOI). If EOI is required, you will have no coverage until your EOI is approved.

LTD Plan Pre-Disability Earnings

For purposes of the LTD Plan, your pre-disability earnings are your gross monthly salary or wages from Credit Suisse as of the day before your disability begins and may include:

- Commissions and/or discretionary variable incentive awards averaged over the previous 36 months or, if less, the period of your Credit Suisse employment; and
- Pre-tax contributions you made to the Credit Suisse Employees' Savings and Retirement Plan, a non-qualified executive deferred compensation arrangement, or the Credit Suisse Flexible Spending Accounts, or toward the cost of any other Credit Suisse benefits.

Please note: For purposes of pre-disability earnings, commissions and discretionary variable incentive awards are considered based on when they are paid, not awarded.

Pre-disability earnings **do not** include:

- Awards;
- Overtime pay;
- Credit Suisse contributions on your behalf to any deferred compensation arrangement or pension plan; or
- Any other compensation.

If you do not have regular work hours, pre-disability earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or, if less, your period of employment), but in no event will the number of hours be more than 173.

Your **indexed** pre-disability earnings are your pre-disability earnings increased by 7%. This increase takes effect the date the 13th LTD Plan monthly benefit is payable and each annual anniversary of that date (as long as you are receiving benefits continuously under this plan).

When LTD Coverage Begins

Your LTD Plan coverage begins on the first day of active employment. Enrollment in the plan is automatic. If you do not wish to participate in this plan, you must waive coverage.

Please note: Coverage that begins during your first 30 days of employment is not subject to EOI. If you opt out of LTD Plan coverage during your first 30 days of employment and then choose to enroll in this coverage at a later date, you will have to provide EOI to qualify for coverage.

Waiver of LTD Plan Coverage

You may waive LTD Plan coverage at any time by logging on to the Your Benefits Resources™ web site. However, if you waive this coverage and enroll at a later date, you will be required to provide EOI before your LTD Plan coverage begins. If you need to provide EOI, you will receive a form for submitting this information.

Cost of LTD Coverage

You pay 100% of the cost of your LTD Plan coverage using "after-tax contributions." After-tax contributions are taken from your paycheck *after* state, federal, and local income taxes have been deducted. Since you pay these premiums on an after-tax basis, your monthly LTD Plan benefit is 100% non-taxable.

If you become disabled, you will not be required to pay these contributions while receiving LTD Plan monthly benefits.

LTD Benefit Amounts

If you become disabled and are unable to work because of a non-work-related illness or injury—and your disability lasts longer than 180 calendar days—you will be eligible to receive a monthly LTD benefit. This benefit, paid by MetLife, as the disability claims administrator and insurer, will equal 60% of your pre-disability earnings, subject to a minimum of $100 (or, if greater, 15% of your monthly LTD benefit before reduction for other income benefits) and a maximum of $15,000 a month. In no case will your LTD Plan monthly benefit be less than the applicable minimum monthly benefit—unless you are in an overpayment situation or receiving return-to-work incentives (see "Return-to-Work Incentives").

You will begin to accrue this benefit once you complete the applicable elimination period. The elimination period is 180 consecutive calendar days of disability. You will receive your first monthly LTD benefit payment one month later, and will receive subsequent benefit payments each month thereafter as long as you remain disabled—up to the applicable maximum benefit payment period for certain conditions or based on your age when your disability began (see "When Your LTD Plan Benefits Will End").

Changes in Monthly Benefit

The amount of your LTD Plan monthly benefit may change as a result of a change in your earnings. This new monthly benefit will take effect on the date of the change and will apply only to a disability that begins after that date.

If You Were Formerly Employed by Donaldson Lufkin & Jenrette (DLJ)

Certain employees formerly employed by DLJ elected to grandfather their coverage under the DLJ long-term disability plan. Under that plan, these employees have an LTD benefit of more than $15,000 a month. In the event one of these employees becomes disabled, this higher monthly benefit will be paid, up to a maximum of $25,000 a month. While this higher LTD benefit will be subject to the pre-existing condition limitation, the DLJ service of these employees will count toward satisfying the pre-existing condition clause. The pre-existing condition limitation will not apply to all other former DLJ employees.

Temporary Recovery During Your Elimination Period

If you return to work for 30 calendar days or less during your elimination period, those days at work will count toward satisfying your elimination period. However, if you return to work for more than 30 calendar days before you have satisfied your elimination period, you will have to begin a new elimination period.

Other Sources of Income Under the LTD Plan

Your LTD Plan benefit payments will be reduced by other sources of income that you receive because of your disability or retirement, as well as by any benefits available to your spouse and dependents because of your disability or retirement (regardless of marital status or their place of work). However, if you are divorced or legally separated, benefits paid directly to your dependents (and not constructively received by you) will not be counted.

These other sources of income include:

- Any salary continuation plan or other income provided by Credit Suisse or any other employer.
- Any disability benefits under Workers' Compensation law, Unemployment Compensation law, the Railroad Retirement Act, or similar legislation.
- Any accident and health plan sponsored by Credit Suisse that may provide disability benefits.

- Social Security in the form of primary Social Security disability benefits or dependent Social Security disability benefits. (**Please note:** You must apply for Social Security disability benefits as soon as you qualify for these benefits.)
- Any disability income provided by a group, wholesale, or franchise program in which you are enrolled by virtue of your occupation.
- Any individual insurance policy if Credit Suisse contributes or makes payroll deductions toward the cost of this coverage.
- Any other source through which you receive, or are entitled to receive, benefits because of your disability or retirement, except the qualified savings plan, lump-sum pension payouts, and non-qualified deferred compensation plans sponsored by Credit Suisse.
- A no-fault automobile plan.

If you become eligible for any increase in Social Security benefits after you have been receiving benefits under the LTD Plan, the increase in your Social Security benefits will not be deducted from your LTD Plan benefit, provided the LTD Plan is in force at the time the increase occurs.

If you receive other income benefits in a lump-sum payment—for example, as a result of a legal settlement—you must provide satisfactory proof of the breakdown of the amount of the payment attributable to lost income and the time period for which the payment is applicable. Otherwise, the full value of the lump-sum payment may be applied against the benefit payments as an overpayment, reducing the benefit you would otherwise receive from the LTD Plan. As a result, you may not receive a monthly benefit from the LTD Plan until the full value of your lump-sum payment has been exhausted. If you subsequently provide the required proof, your LTD Plan benefits will be adjusted retroactively.

Tax Treatment of LTD Plan Benefits

Because you pay the cost of your LTD Plan coverage through after-tax contributions, your LTD Plan monthly benefits will not be subject to tax when you receive them. If you have questions on the tax treatment that will apply to these benefit payments, contact a professional tax advisor.

Recurring Disability

If you return to work after receiving LTD Plan benefits and within six months you become disabled again due to the same or a related condition, you will not have to complete another elimination period before starting to receive LTD benefit payments again. However, if you complete six or more months of work before becoming disabled again—even if due to the same or a related condition as your prior period of disability—you will have to complete a new 180-calendar-day elimination period before starting to receive monthly LTD benefit payments again.

Please note: If your disability recurs within six months, you will not qualify for any change in LTD benefits that may otherwise apply due to a change in your pre-disability earnings or plan terms, provisions, or conditions.

Concurrent Disability Under the LTD Plan

If a new disability occurs while LTD Plan monthly benefits are payable, it will be treated as part of the same period of disability and monthly benefit payments will continue subject to:

- The maximum benefit payment period based on your age at the time your disability began; and
- Any limitations or exclusions that may apply to the new cause of disability (see "When LTD Plan Benefits Will Not Be Paid").

When LTD Plan Benefits Will Not Be Paid

In general, LTD Plan monthly benefits will not be paid for any disability resulting from:

- War, insurrection, or rebellion;
- Active participation in a riot;
- An intentionally self-inflicted injury or attempted suicide; or
- Committing a felony.

Social Security Assistance Program

Because both you and Credit Suisse pay the cost of Social Security disability benefits—through payroll taxes paid to Social Security—it is important that you apply for the benefits to which you are entitled. That is why, in the event you become disabled, MetLife will assist you in applying for Social Security disability benefits.

You gain a number of advantages when you receive Social Security disability benefits, including:

- **Social Security retirement benefits protection**—Once you are approved for Social Security disability benefits, your earnings record will be frozen as of the date Social Security determines your disability began. This means that the period of time you are disabled—when your income is likely to be less—will not have a negative effect on the calculation of your Social Security retirement and survivors' benefits.
- **Medicare protection**—Once you have received 24 months of Social Security disability benefit payments, you will have Medicare protection for hospital expenses, and you will be eligible for the medical insurance portion of Medicare.

For more information on the assistance available with the Social Security disability application process, contact MetLife.

Please note: Your Credit Suisse health plan will coordinate with Medicare when you become Medicare-eligible. See "When You Become Eligible for Medicare" for more information.

Return-to-Work Incentives

During your elimination period or while receiving disability benefits, you may want to consider participation in MetLife's rehabilitation program. If you do, you will receive:

- Your LTD Plan monthly benefit (including a rehabilitation incentive, when applicable); *plus*
- The amount of your earnings for working while disabled.

During the first 24 months of your LTD benefit payments, this incentive provides you with an opportunity to receive income in addition to your LTD benefit, up to but never more than 100% of your pre-disability earnings. During the first 24 months of LTD benefit payments, your monthly benefit will only be reduced if the total amount you receive from the above sources and other income benefits exceeds 100% of your pre-disability earnings. In that case, your monthly benefit will be reduced so that the amount you receive does not exceed 100% of your pre-disability earnings.

After 24 months, your monthly benefit will be reduced by 50% of your earnings from your work while disabled. Your monthly benefit will be further reduced if the total amount you receive from the above sources and other income benefits exceeds 100% of your pre-disability earnings; it will be reduced by the amount that exceeds the 100%. This benefit will cease on the date you refuse to participate in the rehabilitation program.

For information about this program, see "Early Assistance and Return-to-Work Programs."

Survivors Benefit

If you die while disabled and receiving LTD Plan monthly benefits, the plan will pay a survivors benefit to your eligible survivor(s). This payment will be a lump-sum benefit equal to three times your monthly benefit before reductions based on other sources of income. However, this payment may be reduced based on any overpayment of benefits that the plan is entitled to recover.

Your eligible survivor(s) may include:

- Your surviving spouse (domestic partners are not recognized under this benefit).
- If you do not have a surviving spouse, your unmarried child(ren) or your spouse's unmarried child(ren) under age 25, including adopted children and children placed for adoption. If there is more than one eligible child, this benefit will be divided into equal shares for payment to each eligible child. Payment to a minor child may be made to the child's legal guardian.
- If there is no eligible survivor on the date the survivors benefit is due to be paid, this benefit will be paid to your estate.

This survivors benefit will be paid only if:

- You have completed the 180-calendar-day elimination period;
- You are eligible to receive a monthly benefit at the time of your death;
- You have an eligible survivor; and
- Proof of your death is provided to MetLife.

When Your LTD Plan Benefits Will End

You will receive LTD Plan monthly benefits for as long as you are disabled, up to the following limitations based on your age at the time your disability begins:

If at the time your disability begins, you are:	Your LTD Plan benefits are payable:
Under age 60	Until the 1st of the month until your 65th birthday
Age 60, but under age 65	For 54 months
Age 65, but under age 70	For 30 months
Age 70, but under age 75	For 18 months
Age 75 or older	For 12 months

The time period during which you may receive benefit payments starts from the date of the first payment.

In addition, your LTD Plan monthly benefits will end on the date that the earliest of the following events occurs:

- You reach the end of the maximum benefit payment period;
- You reach the end of the maximum benefit payment period for disabilities due to a specific condition;
- Your disability ends;
- You fail to provide MetLife any required information to substantiate your disability (see "Filing a Claim and Appealing a Denied Claim for Benefits");
- You cease or refuse to participate in a rehabilitation program (see "Return-to-Work Program");
- You fail to attend a medical examination requested by the claims administrator;
- You begin to receive pension benefits from Credit Suisse, if your monthly pension benefit is greater than your monthly LTD Plan benefit; or
- Your death.

If you are disabled and the Disability Benefits Plan terminates or you cease to be an eligible employee—either during the first 180 calendar days of your disability (before monthly benefit payments begin) or while receiving monthly benefit payments—you will continue to be eligible to receive monthly benefit payments from the plan for as long as you remain disabled, up to the applicable maximum benefit payment period based on your age at the time your disability began.

Limitations for Certain Conditions

A separate 24-month maximum will apply to the benefit payment period if you are disabled due to a mental or nervous disorder or disease; unless the disability results from schizophrenia, bipolar disorder, dementia, or organic brain disease. However, in no event will LTD Plan monthly benefits be paid longer than that described in the chart under "When Your LTD Plan Benefits Will End." A mental or nervous disorder or disease means a medical condition of sufficient severity to meet the diagnostic criteria established in the current Diagnostic and Statistical Manual of Mental Disorders. You must be receiving appropriate care and treatment for your condition by a mental health doctor.

In addition, if you are disabled due to alcohol, drug, or substance abuse addiction, LTD Plan monthly benefits will be paid for only one period of disability during your lifetime. You must be participating in an available rehabilitative program recommended by your doctor. In this case, your monthly plan benefits will end on the date the earliest of the following events occurs:

- You receive your 24th monthly benefit payment;
- You no longer participate—or refuse to participate—in an available rehabilitative program; or
- You complete the rehabilitative program.

When Participation Ends

If you are not disabled and are not receiving disability benefit payments, your LTD Plan coverage will end on the date that the earliest of the following events occurs:

- A policy or plan terminates;
- You cease to be an eligible employee; or
- You stop making any required contributions toward the cost of your coverage.

If you are notified of your termination of Credit Suisse employment, your LTD Plan coverage will continue for the lesser of 90 calendar days or until your termination date. You will have up to 31 days to choose to convert your coverage to an individual LTD plan (see "Conversion Privilege").

Conversion Privilege

When your employment ends, you may be eligible to elect coverage under a long-term disability conversion plan. This plan will provide coverage for long-term disability only. To qualify for this coverage you will not be required to provide EOI, but you must meet the following conditions:

- You must have been covered under the conversion privilege for at least 12 months prior to the date your employment ends;
- Your coverage under this plan must end as a result of termination of your employment with the Bank, other than as a result of retirement; and
- You apply in writing and pay the first premium for the LTD conversion plan within 31 days after your coverage under this plan ends.

The format, benefits provided, premium, and other terms of the conversion coverage may differ from those provided under the LTD Plan.

Reinstatement of Coverage

If your LTD Plan coverage ends because you stopped making required contributions toward the cost of your coverage while you are on an approved Family and Medical Leave Act (FMLA) leave of absence, your coverage will be reinstated without you being required to submit EOI, if you subsequently become an eligible employee again within 31 days of returning from an approved leave of absence.

Impact on Other Benefits While on LTD

How your benefits are impacted while you are on LTD depends on when your period of disability began and whether or not you are eligible for Medicare. Please refer to the chart below to see how your benefits are impacted while you are approved for LTD benefits by MetLife[1]:

	If You Were Approved for LTD Benefits:	
	Prior to January 1, 2007	**On or After January 1, 2007**
Health and Insurance Coverage		
Medical and Prescription Drug Coverage		
If you are not Medicare-eligible:	You will be eligible for medical coverage for yourself and your dependents under the Build Your Own Medical Plan Basic Rx copayment option. For a description of this coverage, refer to the Group Health Care Plan Summary Plan Description, which is posted on the Your Benefits Resources web site. See "Resources" for access information.	
If you are Medicare-eligible:	You and your eligible dependents will be eligible for medical and prescription drug coverage. For a description of this coverage, refer to the section "If You Are Receiving Long-Term Disability (LTD) Benefits" in the Group Health Care Plan Summary Plan Description, which is posted on the Your Benefits Resources web site. See "Resources" for access information.	
▪ Coordination with Medicare:	You are required to enroll for Medicare Part A (hospitalization insurance) and Part B (doctor insurance) coverage as soon as you become Medicare-eligible while receiving LTD benefits. See "When You Become Eligible for Medicare" for more information.	
▪ Medicare Part B Premium:	You will receive a reimbursement from Credit Suisse for your Medicare Part B premium.	You are not eligible for a Medicare Part B reimbursement.
Vision Coverage	You will be eligible for vision coverage for yourself and your dependents under the same option you were covered by as an active employee. For a description of this coverage, refer to the Group Health Care Plan	

	If You Were Approved for LTD Benefits:	
	Prior to January 1, 2007	On or After January 1, 2007
	Summary Plan Description, which is posted on the Your Benefits Resources web site. See "Resources" for access information.	
Dental Coverage	You and your eligible dependents will be eligible for dental coverage under the same option you were covered by as an active employee. For a description of this coverage, refer to the Group Health Care Plan Summary Plan Description, which is posted on the Your Benefits Resources web site. See "Resources" for access information.	
Life Insurance	You will be eligible for life insurance coverage for yourself and your dependents under the same options you were covered by as an active employee. For a description of this coverage, refer to the Life and Accident Summary Plan Description, which is posted on the Your Benefits Resources web site. See "Resources" for access information.	
Cost of Coverage for Medical, Dental, Vision, and Life Insurance	Your cost for all health and life insurance coverage will be fully subsidized by Credit Suisse.	You will make the same contributions as an active employee for all your health and life insurance coverage. Your contributions will be based on your salary at the time you were approved for LTD benefits.
You Can Continue Your Medical, Dental, Vision, Life Insurance, and Personal Accident Insurance (PAI) Coverage	Until the end of your LTD benefit period.	Until the earlier of: ▪ The end of your LTD period; or ▪ After 42 months of LTD benefits. When your coverage ends, you may be able to continue coverage under COBRA. You can also elect to convert your life insurance and PAI coverages to individual policies. For a description of COBRA coverage or how to convert your life insurance, refer to the Group Health Care Plan Summary Plan Description, which is posted on the Your Benefits Resources web site. For a description of how to convert your PAI coverage, refer to the Life and

	If You Were Approved for LTD Benefits:	
	Prior to January 1, 2007	On or After January 1, 2007
		Accident Summary Plan Description, which is also posted on the Your Benefits Resources web site. See "Resources" for access information.
If You Die	Health care benefits continue at no cost for your eligible dependents for as long as they meet the eligibility requirements of the plan.	Your eligible dependents would pay for health care benefits at the same rate as active employees as follows: ▪ For your spouse or domestic partner—until age 65; and ▪ For your child(ren)—until age 19 (or age 23, if a full-time student).
Other Benefits		
Savings Plan	Your active participation in the Employees' Savings and Retirement Plan of Credit Suisse ("Savings Plan") ends on the date your LTD benefits begin. While your account balance will remain invested through the Savings Plan, no further contributions will be made to your account as long as you receive LTD benefits. You may request a distribution from the Savings Plan. For more information, see the Employees' Savings and Retirement Plan of Credit Suisse Summary Plan Description posted on the Your Benefits Resources web site. See "Resources" for access information.	
Retirement Plan	Your participation in the Defined Benefit Pension Plan of Credit Suisse ends when your LTD benefit begins. Your pension benefit will be calculated using a pay and service amount frozen as of the date your LTD disability benefits began. For more information, see the Defined Benefit Pension Plan Summary Plan Description posted on the Your Benefits Resources web site. See "Resources" for access information.	
Excess Liability Insurance	You will be eligible for excess liability insurance coverage under the same option you were covered by as an active employee. You will pay the same cost for this coverage as an active employee.	
Vacation	You will not accrue vacation days while you are receiving an LTD benefit.	

[1]If you go on a qualifying leave of absence under the Family and Medical Leave Act ("FMLA"), then to the extent required by the FMLA, the Bank will continue to maintain your participation in your health benefits on the same terms and conditions as if you were an active employee.

Please note: Credit Suisse reserves the right to change or discontinue any benefit offered while you are on leave in its sole discretion.

When You Become Eligible for Medicare

Eligibility for Medicare Coverage

As a recipient of LTD benefits, you are required to apply for Social Security disability benefits. After you have received Social Security disability benefits for 24 months, you are eligible for Medicare Parts A and B. When this happens, Medicare becomes your primary health care coverage and the Credit Suisse Medical Plan automatically becomes the secondary payer of benefits. This means that the Credit Suisse Medical Plan pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether or not you are actually enrolled.

You and/or your dependents also become Medicare-eligible when you and/or they reach age 65.

How Coordination Works

The Credit Suisse Medical Plan will not reimburse a Medicare-eligible participant for expenses covered by Medicare. The amount payable under the Credit Suisse Medical Plan is based on a number of factors including the amount paid by Medicare, your deductible, your coinsurance, and the method of Medicare coordination.

The amount paid as coinsurance from the Credit Suisse Medical Plan will be based on the Medicare Allowable Charge **less** Medicare's Primary Payment. (See Line 3 in the chart below.) The Credit Suisse Medical Plan will never pay more than the **difference** between the Medicare Allowable Charge and the Medicare Primary Payment.

An Example of Coordination With Medicare

An example of how this works appears in the following chart. This example assumes that Medicare is your primary plan, the Credit Suisse Medical Plan is your secondary plan, the Credit Suisse Medical Plan's coinsurance is 80%, and that you have already met the deductible.

1. Medicare Allowable Charge (based on fee schedule) and amount provider accepts as payment in full for services	$150
2. Medicare primary payment (Medicare's coinsurance calculation)	$150 × 80% = $120
3. Credit Suisse secondary payment (coinsurance calculation is equal to 80% of Line 1 minus Line 2)	($150 - $120) × 80% = $24
4. Amount payable from Medicare as primary plan	$120
5. Amount payable from Credit Suisse as secondary plan	$24
6. Total reimbursement amount (cannot exceed Medicare	$144

Allowable Charge) (Line 4 plus Line 5)	
7. Your out-of-pocket costs	$6

The Credit Suisse Medical Plan will determine its payment assuming you are enrolled in Medicare Parts A and B. Therefore, the Credit Suisse Medical Plan will not pay for any expenses that would have been paid by Medicare Parts A and B. If you receive services, and those services are not paid for by Medicare because you are not enrolled in Medicare, you will remain responsible for the cost of those services.

Please note: The Credit Suisse Medical Plan will remain the primary coverage for those receiving LTD benefits who are not Medicare-eligible or are denied Medicare enrollment. Eligible dependents who are not Medicare-eligible will also have primary coverage under the Credit Suisse Medical Plan.

How to Enroll in Medicare Parts A and B

The Social Security Administration handles Medicare eligibility and enrollment. Contact the Social Security Administration at **1-800-772-1213** or visit their web site at **www.socialsecurity.gov**.

Although you pay no premium for enrolling in Medicare Part A, a monthly premium for coverage under Medicare Part B will be deducted from your Social Security disability benefit check.

If You Were Approved for LTD Before January 1, 2007, You Can Apply for Reimbursement of Your Medicare Part B Premium

If your period of disability was approved prior to January 1, 2007, Credit Suisse will reimburse you a portion of your monthly Medicare Part B premium while you receive benefits from the LTD Plan. Beginning January 1, 2007, your reimbursement will be paid to you annually in a single payment by year-end.

In order to receive your reimbursement for Medicare Part B premiums, the tax code requires you to submit proof of your enrollment in Medicare Part B to Credit Suisse each year. If you do not submit this proof to Credit Suisse, you will not be reimbursed for your Medicare Part B premiums.

Acceptable forms of proof are:

- A photocopy of your Medicare card showing that you are enrolled in Medicare Part B; or
- A photocopy of your letter from the Centers for Medicare & Medicaid Services (CMS) showing that you are enrolled in Medicare Part B.

You should mail or fax your proof of Medicare Part B enrollment to:

Credit Suisse Benefits Service Center
P.O. Box 785092
Orlando, FL 32878-5092
Fax: **1-847-554-1273**

The reimbursed amount is based on federal guidelines and is subject to change each year.

Filing a Claim for LTD Benefits

If your disability lasts longer than 180 calendar days, the claims administrator (MetLife) will initiate the claim process for LTD benefits. You will have to submit—at your own expense and subject to the claims administrator's satisfaction—certain required information, including:

- Proof of disability;
- Evidence of continuing disability;
- Proof that you are under the appropriate care and treatment of a doctor throughout your disability;
- Information about other income benefits; and
- Any other material information related to your disability.

Proof of disability must be submitted within 30 days after the end of your elimination period—180 calendar days of consecutive disability. No benefits will be payable for claims submitted more than three months after the date of disability. However, you can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give written proof of disability during the three-month period; and
- Proof of disability satisfactory to the claims administrator was given as soon as reasonably possible.

You will receive written notification from the claims administrator regarding your claim within a reasonable time period, but not later than 45 days after receipt of the claim by the claims administrator. This initial notification period may be extended up to two times for up to 30 days each (up to a total of 105 days). If an extension is necessary due to matters beyond the control of the plan, you will be notified before the end of the initial 45-day period and, if a second extension is needed, by the end of the initial 30-day extension period, why the extension is necessary and when a decision is expected to be made.

If an extension is necessary because you failed to submit necessary information to decide the claim, the notice will specify what additional information is necessary. You will have at least 45 days to provide the requested information.

If Your Claim for LTD Benefits Is Denied

If your claim for LTD benefits is denied, in whole or in part, the written notification you receive will include:

- The specific reasons for the denial;
- The specific plan provisions on which the denial is based;
- If an internal rule or guideline was relied upon in making the adverse determination, either the specific rule or guideline; or a statement that such rule or guideline was relied upon to determine a claim and will be provided free of charge to the claimant upon request;
- Any additional material or information that is needed to perfect the claim and an explanation of why it is necessary; and

- The plan's claim-review procedures, applicable time limits, and a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following a denial on review.

Filing an Appeal

After receiving the denial notice, you or your authorized representative may ask for a full and fair review of the decision by writing to the claims administrator.

You are entitled to be represented by an attorney or other authorized person through all phases of the review process, including reconsideration of a denied claim.

You must make this request within 180 calendar days of the date you receive written notice of the denied claim. You or your authorized representative will be given reasonable access to all documents, records, and information relevant to the claim for benefits, and you may request copies free of charge. You also can submit written comments, documents, records, and other information relating to the claim. Review of your claim will take into account all comments, documents, records, and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

Appeal Decision

The claims administrator will review the appealed claim and make a decision based on all comments, documents, records, and other information that you have submitted.

Discretionary Authority of Claims Administrator

The claims administrator will serve as the final reviewer of the LTD Plan. It will have sole and complete discretionary authority to determine conclusively for all parties claiming to have an interest in the plan, and in accordance with the terms of the documents and instruments governing the plan, any and all questions arising from or relating to the administration and interpretation of the plan. This authority includes, without limitation, determination of questions arising from or relating to the participation of eligible employees and eligibility for benefits, the relevant facts, the amount and type of benefits payable to any participant, and the construction of all terms of the plan. Decisions by the claims administrator will be final, conclusive, and binding on all parties claiming to have an interest in the plan. Benefits will be paid under the plan only if the claims administrator decides in its discretion that the participant or other claimant is entitled to them.

Timing of Notification of Appeal Decision

In most cases, you will receive the claims administrator's written notification of the appeal decision within a reasonable period of time, but not later than 45 days after receipt of the appeal request. If necessary, the period may be extended for an additional 45 days.

If special circumstances require additional time for processing your request, you will be notified as to why an extension is necessary and when a decision is expected to be made.

If your appeal is denied, in whole or in part, you (or your beneficiary) will receive a written notice that contains:

- The specific reason(s) for the denial;
- The specific plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the claim;
- A statement describing your right to bring an action under ERISA section 502(a); and

- If an internal rule or guideline was relied upon in making the adverse determination, either the specific rule or guideline; or a statement that such rule or guideline was relied upon to determine a claim and will be provided free of charge to the claimant upon request.

If you exhaust all levels of appeal, you may file a suit under ERISA (see "Your Rights Under ERISA"). You cannot bring a civil action at law or in equity for plan benefits unless you exercised your right to appeal your claim denial.

Eligibility for benefits is intended to be determined solely on the basis of information supplied to the claims administrator. Benefits cannot be granted or denied on the basis of information that has not been submitted in connection with a claim. Benefits will be paid only if the claims administrator, or its delegate, decides in its discretion that you are entitled to them.

Early Assistance and Return-to-Work Programs

Assistance Programs

The goal of these programs is to focus on the abilities—not disabilities—of each disabled employee, to help them return to work as soon as possible. The assistance these programs provide is available at no cost to you.

Early Assistance Program

This program is designed to help identify disabled employees who might benefit from vocational analyses and rehabilitation services.

While participation in this program is voluntary, it is important to know that the earlier rehabilitation services begin the shorter the period of disability is likely to be and the sooner you can return to work.

Through this program, MetLife's rehabilitation coordinators—with your permission—may assist you by:

- Reviewing and evaluating your disability condition—even before you submit a claim for Long-Term Disability (LTD) benefits;
- Designing individualized return-to-work plans;
- Identifying local community resources;
- Coordinating services with other benefit providers; and
- Monitoring your return-to-work plans in progress and modifying these plans as recommended by the attending physician.

Return-to-Work Program

Vocational Rehabilitation Services

This program focuses on identifying the necessary training and therapy that can help you return to work. Participation in this program requires review and approval by Credit Suisse. These services include:

- Assessment, counseling, and training to help determine how your skills and abilities can be applied to a new or modified job with Credit Suisse;
- Programs to facilitate your return to your previous job, or train you for a new job; and
- Changes that could help you perform your previous job or a similar job, as required under the Americans with Disabilities Act (ADA).

Rehabilitation Staff

Your case manager may refer you to MetLife's professional rehabilitation staff which includes:

- Registered nurses who can address how your disability might impact your ability to return to work; and
- Vocational rehabilitation coordinators who will focus on identifying how your abilities can be best applied to either your previous job or a new job.

These rehabilitation specialists will contact you directly and will coordinate their activities with your medical carrier and/or attending physician.

Rehabilitation Vendor Specialists

Independent rehabilitation vendor specialists may be called upon to work with you and your doctor in support of program goals. Their involvement will be based on:

- Your attending physician's evaluation and recommendations;
- Your individual vocational needs; and
- The vendor's credentials, specialty, reputation, and experience.

Filing a Claim and Appealing a Denied Claim for Benefits

Claim Information

Detailed instructions for filing a claim and, in the case of a claim for Short-Term Disability (STD) and Long-Term Disability (LTD) benefits, appealing a denied claim for benefits are provided in the sections of this SPD describing each type of disability coverage, as noted below:

- See "Filing a Claim for STD Benefits" and "If Your Claim for STD Benefits Is Denied"; and
- See "Filing a Claim for LTD Benefits" and "If Your Claim for LTD Benefits Is Denied."

Your Rights Under ERISA

Overview

Participants in the insured portions of the Disability Benefits Plan—the Long-Term Disability (LTD) Plan—are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that these participants be entitled to the following:

Receive Information

- Receive information about the plan and benefits.
- Examine (without charge) at the plan administrator's office and at other specified locations—such as in a local Human Resources department—all plan documents. These may include contracts and copies of all documents filed with the U.S. Department of Labor (for example, detailed annual reports [Form 5500 Series] available at the Public Disclosure Room of the Employee Benefits Security Administration [EBSA]).
- Obtain copies of documents governing the Disability Benefits Plan, including copies of the latest Form 5500 annual report and an updated Summary Plan Description (SPD) by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Disability Benefits Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Short-Term Disability Plan (to the extent it is subject to ERISA) and the Long-Term Disability Plan. The people who operate the plans, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your ERISA rights.

Enforce Your Rights

If your claim for benefits under an insured portion of the Disability Benefits Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge), and to appeal any denial (all within certain time schedules).

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the plan administrator's control.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If you disagree with the plan's decision, you may file suit in a federal court.
- If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.
- If you file suit against the plan, the court decides who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA at **1-866-444-3272**;
- Logging on to the Internet at **www.dol.gov/ebsa**; or
- Contacting the EBSA field office nearest you.

Plan Administration

Group Disability Benefits Plan Administration Chart

Here is some information about the Short-Term Disability (STD) Plan and Long-Term Disability (LTD) Plan and the people who have responsibility for their operation.

Plan Sponsor	Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010
Plan Name	The official name of the plan that provides your STD and LTD coverage is the Group Disability Benefits Plan for Employees of Credit Suisse Securities (USA) LLC (the "Disability Benefits Plan"). This plan is a component plan in the Credit Suisse Securities (USA) LLC Group Health Care Plan. You will need to use this name if you ever need to correspond with a government agency about the plan.
Plan Type	The Disability Benefits Plan is a welfare plan subject to ERISA only to the extent that the Disability Benefits Plan pays benefits pursuant to an insurance policy. The LTD Plan portion of the Disability Benefits Plan is subject to ERISA. The remainder of the Disability Benefits Plan is either a payroll practice or is maintained pursuant to state disability benefits laws, neither of which are subject to ERISA.
Plan Number	The number assigned to the Credit Suisse Securities (USA) LLC Group Health Care Plan is 517.
Plan Year	The plan year is the calendar year—January 1, 2013 through December 31, 2013.
Plan Administrator	The plan administrator is the Benefits Committee. The Benefits Committee has delegated certain plan administration responsibilities with respect to eligibility to the Credit Suisse Benefits Service Center. To contact either party, use the following information: Credit Suisse Benefits Service Center P.O. Box 785092 Orlando, FL 32878 **1-888-325-2732** In addition, the Benefits Committee has delegated the authority

	to determine claims and appeals for the STD Plan and LTD Plan to the claims administrator and insurer.
Claims/Administrator/Insurer	MetLife is the administrator for claims and appeals for the STD Plan, including any state-provided benefits available to employees who work in New Jersey and New York, and for the LTD Plan. MetLife is the insurer for the LTD Plan. The state of California is the administrator for claims and appeals for the state-provided benefits available to employees who work in California.
Employer Identification Number	The Internal Revenue Service (IRS) has assigned Credit Suisse Employer Identification Number 05-0546650.
Costs of the Plans	Credit Suisse pays the full cost of the STD Plan (although employees who work in New Jersey, New York, and California pay a contribution toward the cost of their state-provided STD benefits). LTD Plan participants pay the cost of their coverage through payroll deductions. Benefits under the LTD Plan are paid by Credit Suisse insurance policies.
Agent for Service of Legal Process	Legal process against the STD Plan and the LTD Plan in the event of an unresolved dispute over benefit plan provisions can be served on the plan administrator or the following individual: Corporate Secretary Credit Suisse Securities (USA) LLC Eleven Madison Avenue New York, NY 10010 **1-212-325-2000** For disputes arising under those portions of these plans that are insured by MetLife, service of legal process may be made upon MetLife at one of its local offices or upon the supervisory official of the Insurance Department in the state in which you work.

Reminder: It is your responsibility to notify the plan administrator of your current address so that you continue to receive updates about the plan. Any correspondence sent to your address on file will be deemed to have been received by you for all plan purposes. Benefits can be forfeited after a certain amount of time if you do not provide updated contact information to the plan.

Plan Continuance

It is hoped that the STD Plan and LTD Plan will continue indefinitely. However, Credit Suisse reserves the right to modify, suspend, or terminate them by action of the Benefits Committee, or its designee. Any such action would only be taken after careful consideration; however, plan modification, suspension, or termination is not contingent upon the financial condition of the Bank.

Plan Documents

This SPD contains important details about the STD Plan and LTD Plan. It does not create a contract of employment between Credit Suisse and any employee. You can find complete details in the official legal documents of the plan, including insurance contracts. If there is any difference between this SPD and those legal documents, the legal documents will govern.

Resources

Resources Offered by the Bank

Credit Suisse gives you access to resources to help you manage your benefits and get the most out of the programs the Bank offers.

The Your Benefits Resources web site should be your first stop for information about your benefits. You can access the web site in two ways:

- From the Credit Suisse HR Intranet: Go to the HR homepage, click **Benefits**, then click Your Benefits Resources. Re-enter your NT login ID and password.
- From outside the Credit Suisse HR Intranet: Enter the web site address into your browser window: **http://resources.hewitt.com/credit-suisse**. (The first time you log on, you will be prompted to create a Benefits Access ID and password.)

Log on to the web site to:

- Enroll for your benefits when newly hired or during the Annual Enrollment period in the fall;
- Review your current, personalized benefit information; or
- Take advantage of the valuable tools and resources available to help you make the most of your benefits.

The Credit Suisse Benefits Service Center is available when you need personal attention to answer a benefits question or issue. To reach the Credit Suisse Benefits Service Center, call **1-888-325-2732**. Representatives are available to assist you Monday through Friday, from 9:00 a.m. to 5:00 p.m., Eastern time. They will be glad to assist you in any way they can.

Call the toll-free telephone number to:

- Speak with a Credit Suisse Benefits Service Center representative; or
- Connect to MetLife, the disability administrator.

Resources Offered by the Claims Administrator

MetLife gives you two ways to access Short-Term Disability (STD) Plan and Long-Term Disability (LTD) Plan information:

- Call **1-800-858-6506** to access information about your claim; or
- To download forms, log on to **www.metlife.com** and click **Forms Library** in the upper right-hand corner and select Disability.

Information for California Employees

If you work in California, the state offers two resources for the state disability program:

- Log on to **www.edd.ca.gov**; and
- Call **1-800-480-3287**.

Information on Your Rights

To request publications about your rights and responsibilities under ERISA, you can contact the Employee Benefits Security Administration (EBSA) at **1-866-444-3272** or **www.dol.gov/ebsa**.

Information on Other Plans

For information on other Credit Suisse benefit plans, including those mentioned in this document, please see the Summary Plan Descriptions (SPDs). SPDs for all Credit Suisse plans are posted on the Your Benefits Resources web site. Access the site through the HR Intranet's Benefits Page or directly at **http://resources.hewitt.com/credit-suisse**.